

MAMMOGRAPHY WORKSHEET

Patient's last name		First/MI	Date of birth / /	Age	Home Ph
Work Ph	Patient's address		City	St	Zip
MR#	Referring doctor				

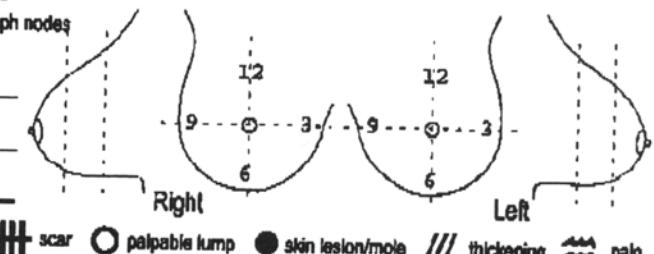
Risk Factors ☐ No children ☐ Late child bearing (after 30) ☐ BC Gene ☐ Family history of BC: ☐ Aunt, grandmother, cousin ☐ Mother ☐ Sister 1 ☐ Sister 2 ☐ Daughter

Personal history of cancer: ☐ Breast ☐ Endometrial ☐ Ovarian ☐ Colon ☐ Y ☐ N Before menopause ☐ ☐ ☐

Breast Surgical, Treatment & Hormone History
Indicate:
date - type; result

First mammogram ☐ Last mammogram was yrs mos ago ☐ Hold For Previous

<input type="checkbox"/> Screening <input type="checkbox"/> Clinical finding <input type="checkbox"/> addit. Evaluation requested at current screening <input type="checkbox"/> follow-up at short interval from prior study <input type="checkbox"/> Addit. evaluation requested from prior study <input type="checkbox"/> pre-reduction mammoplasty <input type="checkbox"/> pre-radiation therapy <input type="checkbox"/> history of breast augmentation, asymptomatic <input type="checkbox"/> review of prior study <input type="checkbox"/> +Other <input type="checkbox"/> review of an outside study <input type="checkbox"/> Diagnostic	<input type="checkbox"/> palpable abnormality <input type="checkbox"/> cancer elsewhere <input type="checkbox"/> bloody discharge <input type="checkbox"/> large axillary lymph nodes <input type="checkbox"/> non-bloody discharge <input type="checkbox"/> +Other: <input type="checkbox"/> difficult physical Exam <input type="checkbox"/> breast implant problem <input type="checkbox"/> skin thickening or retraction <input type="checkbox"/> Lump or thickening <input type="checkbox"/> Nipple abnormality <input type="checkbox"/> Pain	Tech initials Event Date / /
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Physical findings:

Views: <input type="checkbox"/> Routine <input type="checkbox"/> Special View <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Digital: Std.	Exam by	<input type="checkbox"/> Exam not performed, so advise patient to obtain
Spot comp. Mag.		
There is a are benign-appearing suspicious multiple density high equal low radiolucent round oval lobulated irregular architectural distortion with well-defined circumscribed microlobulated ill-defined indistinct obscured spiculated margins in the breast o'clock ui uo li lo position right left bilateral anterior posterior middle subareolar central axil. tail consistent with	There is a are benign-appearing suspicious indetermin. scattered regional segmental clustered round linear skin vascular coarse rod-like lucent-centered heterogeneous suture dystrophic punctate milk of calcium amorphous indistinct branching pleomorphic eggshell granular in the breast o'clock ui uo li lo position right left bilateral anterior posterior middle subareolar central axil. tail consistent with	

<input type="checkbox"/> Asymmetric breast tissue <input type="checkbox"/> Focal asymmetric density <input type="checkbox"/> No discrete abnormality <input type="checkbox"/> Including area of concern:	R L Stable Mass R L Stable Ca ++ R L Stable Scar
<input type="checkbox"/> No significant new finding since: <input type="checkbox"/> Films compared with: <input type="checkbox"/> Finding is New / Changed when compared:	

Films from:

<input type="checkbox"/> Negative (1) <input type="checkbox"/> Benign (2) <input type="checkbox"/> Probably benign (3) <input type="checkbox"/> Suspicious (4) <input type="checkbox"/> Highly suggestive of Malignancy (5) <input type="checkbox"/> Incomplete: need Additional imaging evaluation (0)	<input type="checkbox"/> Follow-up mamm. in yrs mos <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> at 40/ <input type="checkbox"/> Back to screening <input type="checkbox"/> No Follow-up <input type="checkbox"/> Special View(s) <input type="checkbox"/> R <input type="checkbox"/> L mos Std Spot Mag <input type="checkbox"/> Ultrasound <input type="checkbox"/> R <input type="checkbox"/> L mos <input type="checkbox"/> If needed <input type="checkbox"/> Clinical Exam mos <input type="checkbox"/> Aspiration <input type="checkbox"/> Core Biopsy <input type="checkbox"/> By stereo <input type="checkbox"/> By ultrasound <input type="checkbox"/> Surgical Consultation <input type="checkbox"/> Old films not available <input type="checkbox"/> Repeat Film(s) <input type="checkbox"/> + Other <input type="checkbox"/> Further Imaging <input type="checkbox"/> Ductogram <input type="checkbox"/> Breast MRI <input type="checkbox"/> Called <input type="checkbox"/> Faxed report
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